ANNUAL MEDICAL PAYMENT REPORT

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Due by February 28th Year Ending 200_

I. CARRIER INFORMATION

Carrier Name	Carrier NAIC No., Self-Insured No., or FEIN No
Carrier Address (Street)	Carrier Telephone No. (Include area code)
Carrier City, State, ZIP Code	Carrier Contact Person
Service company or Review Company submitting the Information	Contact Person and Telephone No. (Include area code)

II. ANNUAL MEDICAL PAYMENT REPORT

Include data for payment of all medical expenditures.

Do not include payments for the following:

a. Indemnity payments
b. Mileage reimbursement
c. Vocational rehabilitation or medical case management expenses
d. Independent medical examinations or legal expenses

Case Type	**Number of Cases**	**Total Dollars Spent for Medical Care**
Medical Only		$
Wage Loss		$

By signing this form, I certify that the information included in this annual medical payment report and accompanying attachments, if any, is true, correct and complete to the best of my knowledge.

Authorized Signature (In ink)	Authorized Name (Typed)	Date

Authority: Workers' Compensation Health Care Services Rules, part 14, R 418.101401
Completion: Mandatory. Must completed and submitted to the bureau by 2/28 annually for the previous year.
Penalty: Failure to provide data shall prevent certification of the Carrier's Professional Health Care Review Program pursuant to Part 12, R 418.101206